CITY OF BALTIMORE

MARTIN O'MALLEY, Mayor

HEALTH DEPARTMENT

PETER BEILENSON, M.D., M.P.H., Commissioner
210 Guilford Avenue
Baltimore, Maryland 21202

Oral Health Services
General Consent Form

I, the undersigned, hereby give consent to the doctors of the Druid/Eastern Dental Clinic to perform examination(s), take radiographs, tests and use any other diagnostic aid deemed appropriate by the doctors to make a diagnosis of my or my child's dental health or related medical problem(s).

I also give consent to the doctors to perform any and all forms of treatment, prescribe medication and recommend therapy that may be indicated.

I understand that these procedure(s) and the use of anesthetic agents pose certain risk(s), nonetheless, I give my consent.

In the case of oral surgery treatment (i.e., extractions, tooth pulling): I understand that there may be possible complications and side effects following such treatment. These complications and side effects may include, but are not limited to: nausea, referred pain to the ear, neck or head, allergic reactions, swelling, excessive bleeding, bruising, discoloration, delayed healing and infection. Temporary or permanent numbness and tingling of the lip, tongue, chin or teeth may also occur.

Medications, drugs, anesthetics and prescriptions may cause drowsiness, lack of coordination and other side effects, which will increase if alcohol or other drugs are ingested.

I understand that home care instructions will be given to me after the treatment has been rendered.

For patients 17 years – younger: (please circle one)
For treatment of children in the absence of the parent or guardian:
I **DO/ DO NOT** give permission for _____ to be treated in my absence.
Name of child

_____
Patient signature (parent or legal guardian if child is a minor) Date

_____
Relationship to child

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